

STANDARD CERTIFICATE OF DEATH

32691

State File No. 1037  
Registrar's No. 1037

FILED OCT 15 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000

1. PLACE OF DEATH  
a. COUNTY Buchanan, Buchanan

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Missouri b. COUNTY Buchanan

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph c. LENGTH OF STAY (in this place) 37 yrs.

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2220 Sylvania St.

d. STREET ADDRESS (If rural, give location) 2220 Sylvania

3. NAME OF DECEASED (Type or Print)  
a. (First) ESTEL b. (Middle) YOUNG c. (Last) STRAWN

4. DATE OF DEATH (Month) (Day) (Year) 10/5/51

5. SEX Male 6. COLOR OR RACE Coloree 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 5/25/1887 9. AGE (In years last birthday) 64 IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician

10b. KIND OF BUSINESS OR INDUSTRY Medical Doctor

11. BIRTHPLACE (State or foreign country) Columbia, Mo. 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Arthur Strawn 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE Ruth E. Strawn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Ruth Strawn, 2220 Sylvania, St. ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) cardiac failure INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) chronic myocarditis

DUE TO (c) hypertension

II. OTHER SIGNIFICANT CONDITIONS: Chronic glomerulo-nephritis

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 443X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-5-51, 19  , to 10-5-51, 19  , that I last saw the deceased alive on 10-5-51, 19  , and that death occurred at 2 P. m., from the causes and on the date stated above.

23a. SIGNATURE E. Hayden (Degree or title) M. D. 23b. ADDRESS 311 Physician & Surgeons, St. Joseph, Mo. 23c. DATE SIGNED 10-6-51

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 10/6/51 24c. NAME OF CEMETERY OR CREMATORY Columbia, Mo. 24d. LOCATION (City, town, or county) (State) Columbia, Mo.

DATE REC'D BY LOCAL REG. Oct 10, 1951 REGISTRAR'S SIGNATURE Carl C. Cash 25. FUNERAL DIRECTOR'S SIGNATURE Beatrice Gray ADDRESS 819 Pacific St

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

OCT 17 1951

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Lice J. Cheney* \_\_\_\_\_

Licensed Embalmer No. *4679* \_\_\_\_\_

P. O. Address *St. Joseph, Mo* \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.